BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
ANTHONY BAXTER CHIN, M.D.	)	**File No. 8002015011874**
Physician's and Surgeon's Certificate No. A61618	)	**OAH No. 2017051346**
Respondent	)	

DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on April 25, 2018.

IT IS SO ORDERED March 26, 2018.

MEDICAL BOARD OF CALIFORNIA

By: _____
Ronald H. Lewis, M.D., Chair
Panel A

BEFORE THE
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DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ANTHONY BAXTER CHIN, M.D., Physician and Surgeon's Certificate No. A61618, Respondent.	Case No. 800-2015-011874 OAH No. 2017051346

PROPOSED DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH), on January 2, 3, 22, 23, 24, and 25, 2018, in Los Angeles, California. Complainant was represented by Rebecca L. Smith, Deputy Attorney General. Anthony Baxter Chin, M.D. (Respondent) was represented by Henry Fenton and Nicholas D. Jurkowitz, with Fenton Law Group.

At the hearing, the ALJ was provided with Exhibits 5, 6, 7, 9, 11, 12, 14, 16, 29, and K, containing confidential medical information which is protected from disclosure to the public. Redaction of the documents to obscure this information was not practicable and would not provide adequate privacy protection. In order to prevent the disclosure of confidential information, concurrent with the issuance of this Proposed Decision the ALJ, on her own motion, issued a Protective Order providing that Exhibits 5, 6, 7, 9, 11, 12, 14, 16, 29, and K shall be placed under seal following their use in preparation of the Proposed Decision. These exhibits shall remain under seal and shall not be opened, except by order of the Medical Board of California, by OAH, or by a reviewing court. A reviewing court, parties to this matter, their attorneys, or a government agency decision maker or designee under Government Code section 11517 may review the documents subject to this order provided that such documents are protected from release to the public.

Oral and documentary evidence was received, and argument was heard. The record was left open until February 9, 2018 to allow the parties to submit closing briefs. Complainant timely filed "Complainant's Closing Argument," which was marked as Complainant's Exhibit 31 and lodged. Respondent timely filed "Respondent's Closing Argument," which was marked as Respondent's Exhibit M and lodged. The record was closed, and the matter was submitted for decision on February 9, 2018.

FACTUAL FINDINGS

1. On April 18, 2017, Complainant Kimberly Kirchmeyer filed the Accusation in this matter while acting in her official capacity as the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs.

2. On February 14, 1997, the Board issued Physician and Surgeon's Certificate Number A61618 to Respondent. Respondent's Certificate was in full force and effect at all relevant times and is scheduled to expire on September 30, 2018. The license has not been previously disciplined.

Facts re: Patient CO[1]

3. Patient CO was a pregnant 31-year-old female when she sought prenatal care with Respondent on June 8, 2012. She had two prior pregnancies, with no live births. Respondent performed an ultrasound which revealed a twin gestation.

4. Respondent documented that Patient CO's last menstrual period (LMP) was March 21, 2012, giving her an estimated due date (EDD) of December 26, 2012. (Exhibit K, p. 20; Exhibit 5, p. 8.)

5. At the first prenatal visit, Respondent discussed generally with Patient CO how carrying twins is different from carrying a singleton.[2] The patient indicated that she did not want a Cesarean section (C-section).[3] Respondent informed her that there were more contraindications for vaginal delivery of twins than for singletons, that it was more common to deliver twins via C-section, and that he could not guarantee against ultimate delivery by C-section. However, he noted if she was a good candidate, she could deliver vaginally.

6. At the first prenatal visit, Patient CO completed an initial intake form which asked for medical and surgical history. At the section which asked about "sickle cell anemia or trait," Patient CO wrote "SC disease." (Exhibit K, p. 56.) She also indicated that she received a blood transfusion in 1990.

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[1] Patients' initials are used in lieu of full names in order to protect their privacy.

[2] Any factual findings regarding Respondent's discussions with the patient are based on Respondent's credible testimony.

[3] A Cesarean section is the delivery of a baby through a surgical incision in the mother's abdomen and uterus.

7. In a note on the patient's initial visit, Respondent documented "HbS" (Exhibit K, p. 20; Exhibit 5, p. 8), which was his shorthand for "hemoglobin sickle." (Respondent's testimony.) He included this note because he recognized that sickle cell disease is a potential problem which may cause anemia or lead to a crisis requiring blood transfusion. Respondent understood that pregnancy is stressful on the mother's body and that a lengthy history of stability did not preclude sickle cell crises arising during pregnancy.

8. At the first prenatal visit, Respondent discussed the patient's 1990 blood transfusion and her sickle cell disease. He noted that the patient had not needed a blood transfusion for 22 years. He and Patient CO talked about what medication to use if she suffered any sickle cell crises, and he noted that she had an anaphylactic reaction to aspirin. (See also Factual Finding 12.) However, he determined that they did not need to take any action for her disease at that time since she was completely asymptomatic.

9A. On June 12, 2012, Patient CO had blood drawn for laboratory analysis. In the June 17, 2012 laboratory report from that blood draw, the following values were noted: red blood cell count 3.43 (low compared to the reference range of 3.80-5.10); hemoglobin 10.0 (low compared to the reference range of 11.7-15.5); and hematocrit 31.7 (low compared to the reference range of 35.0-45).

9B. Respondent read the June 17, 2012 laboratory report and handwrote on the report the word "sickle" as a reminder that the patient had sickle trait which explained why she had low hemoglobin.

9C. Respondent reviewed the laboratory results with Patient CO on June 18, 2012, and he discussed the significance of the findings with her. He noted her low hemoglobin and hematocrit values and suggested that these were probably her baseline values due to her sickle disease. Respondent recommended that Patient begin taking liquid iron supplements to increase her hemoglobin and hematocrit, which could lessen any anemia. On the laboratory report, Respondent handwrote "6/18/12 spoke" and signed below that notation. (Exhibit K, p. 7; Exhibit 5, p. 51.)

10. Patient CO had 11 prenatal visits with Respondent. An ultrasound was performed at each visit to measure the growth of the twins.

11. For each prenatal visit, Respondent created a written progress note on a standard form. He also printed out the ultrasound pictures at each visit. There were several ultrasound pictures generated for each visit, and the final ultrasound "picture" in the series was a typewritten report summarizing the data obtained during the ultrasound, including measurements of each twin, estimated fetal weight, and estimated gestational age based on size. Since there were 20 measures contained in each ultrasound report, Respondent determined that it was quicker to staple the ultrasound pictures and ultrasound summary onto

each progress note, rather than handwriting the 20 separate measurements on the progress note. At subsequent visits, Respondent was able to read the original ultrasound pictures and summaries to ascertain the necessary information for the patient.[4]

12. At the initial visit, on his progress note,[5] Respondent noted the following (converted from his shorthand): "New Patient here for possible OB care. Patient for sickle cell used to take aspirin but now allergic with anaphylaxis. Now treating with morphine. Approximately 11 1/2 weeks status post spontaneous abortion [i.e., miscarriage] December 10. Would like to switch [to retain Respondent as her obstetrician]. LMP 3/21/12 with EDD 12/27/12. Ultrasound for size. Twins! 11 4/2 x 2 [estimated gestational age]. 12/24/12 [EDD based on ultrasound]. Presence of fetal movement x 2. Presence of fetal heart beat x 2." (Exhibit K, p. 60.) Respondent signed the note and instructed CO to return to his clinic in two weeks.

13A. Respondent did not record maternal weight during his prenatal care and treatment of Patient CO.

13B. Measuring maternal weight helps determine the growth of a fetus. In Respondent's experience, using maternal weight to determine the estimated fetal weight (EFW) of twins is "very inaccurate" since there are two amniotic sacs involved, and he cannot ascertain if both babies are growing adequately or if one is grossly small. Consequently, Respondent prefers to perform serial growth scans to measure fetal growth.

14A. Respondent did not record Patient CO's blood pressure until her October 31, 2012 visit at 32 weeks gestation.

14B. At the administrative hearing, Respondent credibly testified that he personally takes patients' blood pressure because he feels it is an important piece of information for him

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[4] During the pendency of the administrative hearing, Respondent discovered that when his medical records for Patient CO were being copied by the staff member at Respondent's medical office, information had been inadvertently omitted. Some of the handwritten information on the progress notes was obscured by the stapled-on ultrasound pictures. Additionally, since the ultrasound pictures in Respondent's original file were stapled in an overlapping or folded-over manner, not all of the original ultrasound pictures were copied for production to Complainant. Given that the information omitted was helpful rather than detrimental to Respondent, this oversight by Respondent's staff is not construed as an intentional attempt by Respondent to withhold documents from the Board.

[5] Respondent's handwritten note for this visit was partially obscured by the ultrasound picture in the photocopied version produced to Complainant. Consequently, the experts were not provided Respondent's full progress note.

to know. Respondent confirmed that he took CO's blood pressure at every visit. However, he acknowledged that, "unfortunately, [he does] not always write it down." He explained that, if a patient's blood pressure is abnormal, he records it and documents a plan on how to address that abnormality. However, Respondent apparently did not document only abnormal readings since CO's documented blood pressure readings were within normal limits. Respondent insisted that CO never had an abnormal blood pressure. Nevertheless, since Respondent is unable to independently recall CO's undocumented blood pressure readings, it is possible that he failed to document abnormal findings. Without seeing the actual blood pressure readings, it is impossible to confirm Respondent's assertion of consistently normal readings.

15. In addition to Patient CO's initial prenatal laboratory work on June 12, 2012, Patient CO participated in the California Prenatal Screening Program which was negative for abnormality. She underwent a formal ultrasound performed at Cedars-Sinai Medical Center (Cedars or the hospital) on August 6, 2012.

16A. During the second trimester, laboratory testing was performed on blood drawn from Patient CO on September 5, 2012. Patient CO's laboratory work reflected a low red blood cell count (3.52 compared to the reference range of 3.9-5.2) and a low hematocrit (30.6 compared to the reference range of 34-45).

16B. Respondent acknowledged that Patient CO's second trimester laboratory blood work reflected a low red blood cell count and low hematocrit. However, he noted that the patient's hemoglobin improved from 10.0 to 11 and that hemoglobin typically decreases during pregnancy.

17A. The September 5, 2012 laboratory testing included a one-hour glucose screening test for gestational diabetes, which is a routine screening test for all pregnant patients. CO's one-hour glucose reading was 135 mg/dL.

17B. The laboratory report noted: "[Americans with Disabilities Act] Criteria for the Diagnosis of Gestational Diabetes: [¶] a plasma Glucose of >130mg/dL after a 50g load and a plasma Glucose of >180 mg/dL after a 100g load indicates the need for additional testing." (Exhibit K, p.66.)

17C. Although CO's one hour glucose reading was above the laboratory's reference range for additional testing, Respondent chose to use a different cut-off for further testing. Respondent understood that the American College of Gynecologists (ACOG) had issued a bulletin noting that screening thresholds for the one-hour glucose test have ranged from 130 to 140 mg/dL, that there was no clear data to suggest the use of any particular threshold in that range, and that ObGyns could select either a135 mg/dL or the 140 mg/dL cutoff for their

practice. Respondent chose the 140 mg/dL cutoff, and he believed that the vast majority of ObGyns also use that cut-off to determine the need for further glucose testing.

18. On November 2, 2012, at 32 weeks, 2 days gestation, Patient CO called Respondent with a complaint of spontaneous rupture of membranes (SROM). At Respondent's request, Patient CO went to Respondent's office, at which time he verified the SROM and sent her to the hospital for further treatment.

19A. Patient CO presented to the hospital as instructed. While still at his office, Respondent prepared a brief note which was entered into the Cedars electronic medical record (EMR) as a "History and Physical" on November 2, 2012. (Exhibit 6, p. 46.) In that note, Respondent documented that Patient CO was a 31-year-old female, with vertex/vertex[6] twins at 32 2/7 weeks gestation, admitted for SROM of Twin A's amniotic sac which was confirmed at 12:30 p.m. The patient had no contractions yet. Respondent noted that the patient was allergic to aspirin, acetaminophen, and Aleve. For the patient's obstetrical history, the EMR indicated, "No LMP recorded. Patient is pregnant, due date of unknown." (Exhibit 6, p. 46.) Respondent documented a plan of "expectant management, antibiotic therapy, and steroid therapy." (*Ibid.*) Respondent did not document the patient's vital signs or past surgical history.

19B. Respondent explained that his "History and Physical" in the Cedars EMR was not an admitting history and physical but was merely a brief admitting note that he generated after he saw CO in his office. He entered this note to let the hospital physicians know why the patient was coming in and to generate a patient number to get CO admitted to the hospital faster. Respondent reasoned that since he prepared the report in his office, it could not be the admitting history and physical because he was not at the hospital. Respondent did not believe that the standard of care required him to provide his note, and he viewed his note in the EMR as "doing more than [he] needed" since he understood that CO would be evaluated at the hospital with an official history and physical. He pointed out that physicians will typically send their patients to the hospital where the patient is seen by a "house officer" who generates the admitting history and physical, including obtaining the patient's vital signs.

20A. At the hospital, Patient CO was seen in consultation by Maternal Fetal Medicine Fellow, Gregory W. Lau, M.D. The Cedars EMR contained Dr. Lau's note which was entitled "Maternal Fetal Medicine Consultation – Inpatient." (Exhibit 6, p. 73.) That note was later reviewed and signed by Maternal Fetal Medicine Faculty member, John Williams, M.D. Respondent was listed as the referring physician, and Dr. Williams was listed as the consulting physician. Dr. Lau conducted a full history (including review of medical,

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[6] Vertex position is where the fetus is in a longitudinal lie, and the fetal head enters the mother's pelvis first.

surgical, obstetrical, gynecological, family and social histories, and drug allergies), and complete physical, including review of vital signs. Dr. Lau noted CO's SC disease and sickle cell trait in her family history, with her "last hospitalization over 7 years ago." (*Ibid.*) An ultrasound was performed to confirm presentation and size estimate. Both twins were in vertex position. Twin B was larger (EFW 1886 grams) than Twin A (EFW 1608 grams) with 15 percent discordance in size. Dr. Lau noted that CO appeared to be in early labor. Drs. Lau and Williams recommended administration of a steroid (betamethasone 12 milligrams intramuscularly every 24 hours for two total doses) and antibiotics (erythromycin and ampicillin for seven days) for treatment of preterm labor, with delivery recommended between 34-35 weeks gestational age. The recommended steroid and antibiotic treatment was initiated.

20B. Respondent characterized the Maternal Fetal Medicine Consultation report as the "admitting history and physical." He noted that Dr. Lau was part of the "house staff" who generate the admitting history and physical reports. However, Respondent also acknowledged that he was Patient CO's admitting and attending physician.

21. On November 2, 2012, Patient CO was also seen by neonatal hospitalist Anuj Desai, M.D., for a neonatal intensive care unit (NICU) consultation.[7] In the consultation note, Dr. Desai noted that Patient CO had been admitted following SROM for Twin A and that she had been admitted to the Maternal Fetal Care Unit. According to Dr. Desai's consultation note, "Mother with a history of Hemoglobin SC disease. Per report of father, he is not a carrier." (Exhibit 6, p. 48.)

22. Patient CO began to have regular contractions and was evaluated for an epidural by anesthesiologist Peter Kim, M.D. Dr. Kim conducted a history and physical, and at 10:12 p.m. he entered a "Pre-OP Note – History and Physical" in the EMR. (Exhibit 6, p. 63.) Dr. Kim noted the patient's hemoglobin SC disease and her allergy to aspirin, acetaminophen and naproxen.

23. Patient CO was evaluated by third year resident Tiffany Herrero, M.D. at 4:03 a.m. on November 3, 2012. CO felt rectal pressure, and upon examination she was 10 centimeters dilated at plus 2 station.[8]

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[7] Dr. Desai's consultation note was later signed by attending physician, Vladana Milisavljevic.

[8] Dilation, measured by centimeters, describes how widened the cervix has become. Fetal station describes how far down the fetus' head has descended into the pelvis and is the measurement of the fetus relative to the ischial spines (e.g., +2 is 2 cm below the ischial spines).

24. At this point, the fetuses were being monitored by an external heart monitor.[9] The fetal monitor strips were reassuring. Respondent was called, and Patient CO was moved to the operating room (OR) for delivery.

25. Patient CO's delivery took place in the OR due to the possibility of complications or the need for a C-section during twin births.

26. Respondent arrived at approximately 4:15 a.m. At about 4:25 a.m., Respondent, Dr. Kim, and Dr. Herrero were at the patient's bedside for delivery of Twin A, along with nursing staff.

27. At 4:38 a.m., Respondent delivered Twin A by spontaneous vaginal delivery. Twin A weighed three pounds, four ounces and had Apgar scores of 8 and 9 at one and five minutes, respectively.[10]

28. Following delivery of Twin A, there was an audible deceleration in the heart rate of Twin B. At about 4:39 a.m., an ultrasound confirmed that the position of Twin B was vertex. Respondent ruptured the membranes.

29A. At the administrative hearing, Respondent credibly maintained that he had recognized Twin B was in distress and that the fetal heart rate was being monitored by ultrasound and an external monitor the entire time Twin B was in distress. The monitoring was audible and visual, so that the fetal heart beat could be heard and seen on the monitor. The heart rate was also digitally recorded via heart rate tracings.

29B. Complainant alleged in the Accusation that "[t]here was no documentation of monitoring the heart rate with the ultrasound machine to confirm a prolonged deceleration." This allegation was contradicted by the evidence.

30A. There was no placement of any internal fetal heart rate monitor on Twin B.

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[9] An external fetal heart rate monitor is a device used to listen to and/or record the fetal heartbeat through the mother's abdomen. An internal fetal heart rate monitor uses a wire electrode attached to the fetal scalp.

[10] An Apgar score is a quick measurement of the overall physical condition of a newborn to determine whether the neonate requires immediate medical care. The assessor assigns a score of 0, 1, or 2, to each of five criteria: the baby's color, heart rate, reflexes, muscle tone and respiratory effort. Those scores are totaled, and the Apgar score is based on the total score of 0 through 10. An Apgar score of 7 and above is typically normal, and a lower score may indicate that the neonate requires medical attention.

30B. Respondent explained that he did not place an internal fetal monitor on Twin B because he could already visualize the fetal heart beat with the ultrasound. Additionally, Respondent noted that an internal monitor could be placed inadvertently on the mother's labia or vagina and would instead pick up the maternal heart beat.

31A. After giving the baby about four to five minutes to recover, Respondent decided that he would need to deliver Twin B as quickly as possible.

31B. Respondent did not document any measures taken to prompt Twin B's heart rate to return to normal.

31C. At the administrative hearing, Respondent recalled that he took measures to return Twin B's heartrate to normal, including giving Patient CO oxygen and a bolus of fluid, wiggling Twin B's head to stimulate him, and rotating Patient CO's position. Respondent believed that the nurses documented these measures. However, other than a notation on the fetal heart rate tracings, "O2[[11]] device . . . O2 start," there was no documentation of any other measures in the nurses' notes.

32A. Testimony and documentary evidence (including nursing notes, physician progress notes, and notations on the fetal heart rate tracings) detailed the progress of Twin B's delivery as follows:

(1). At 4:44 a.m., about five minutes after the deceleration, Twin B's fetal heart rate remained "low in 90s."[12] Respondent "discussed using vacuum assistance" and the patient "verbalized understanding." (Exhibit 6, p. 70.)

(2). Respondent asked for a Kiwi vacuum, and he applied it several times to the scalp of Twin B. Each application resulted in disengagement of the vacuum, detailed more fully below.

(3). According to nursing progress notes and notes on the heart rate tracings, between 4:44 and 4:45 a.m., Respondent applied the vacuum for the first time, but was having difficulty getting an "adequate seal." (Exhibit 6, p. 70; see also Exhibit 29, p.4.)

(4). Between 4:46 and 4:47 a.m., Respondent applied the vacuum a second time, but continued to have difficulty getting an adequate seal, and the vacuum again "popped

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[11] O2 is the abbreviation for oxygen.

[12] Normal heart rate for a fetus is 120-160 beats per minute. Any heart rate below that is considered bradycardia.

off." (Exhibit 29, p. 5; see also Exhibit 6, p. 69.) Respondent then asked for forceps.[13] At 4:47 a.m., the nurse noted, "[Respondent] asking for forceps to help with delivery due to having difficult time achieving adequate seal with vacuum. [Patient] verbalized understanding." (Exhibit 6, p. 69.)

(5). During the time Respondent was unsuccessfully attempting to obtain a good seal with the vacuum, Dr. Herrero instructed one of the first year residents to call Chief Resident Alexandriah Alas, M.D. to the OR. (Exhibit 6, p. 61.)

(6). At 4:48 a.m., Respondent unsuccessfully applied the vacuum a third time. (Exhibit 29, p. 5.) At that time, Dr. Alas arrived "in [the] OR." (Exhibit 6, p. 68.)

(7). From about 4:49 a.m. to about 4:50 a.m., Respondent applied the forceps in an attempt to complete delivery of Twin B. However he could not achieve a good application of the forceps, and he failed to bring the head down. The vertex of Twin B remained at 0 station with no descent.

(8). Respondent then removed the forceps. (Exhibit 29, p. 5.) Following the failed use of forceps, Respondent asked the OR to prepare for a C-section.

(9). At 4:50 a.m., the nurse noted "fetal heart rate remains bradycardic 90-70's. [Respondent] aware [and] consulted to just to [*sic*] emergent [C-]section. . ." (Exhibit 6, p. 69.) At 4:51 a.m., the nurse noted, "[Patient] pushing with forceps no fetal descent noted, [Respondent] having difficult time with position, asked to do emergent [C-]section. [Respondent] talking with [patient] and husband about performing emergent section as fetus B has not descended since [assisted rupture of membranes] and remains bradycardic. [Patient] and husband verbalized understanding. [Patient] prepped for emergent section delivery. (Exhibit 6, p. 69.)

(10). The anesthesiologist, Dr. Kim, testified credibly that the anesthesia for the C-section was delivered through the patient's already existing epidural. Once the C-section anesthesia was administered, it took about two to four minutes to bring the patient to the level where an incision would be tolerated. This two to four minute timeframe is what is typically expected. At any point during the delivery, Dr. Kim could have increased the epidural, and it would have taken two to four minutes to reach an incisional level.

(11). While the OR prepared for the C-section, Respondent reapplied the vacuum a fourth time and was unsuccessful in gaining traction. Respondent then proceeded with the C-section.

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[13] Forceps are grasping surgical instruments used to assist in the vaginal delivery of a fetus by applying traction to the fetal skull.

(12). Twin B was delivered at 4:54 a.m. He weighed four pounds, three ounces with Apgar scores of 3, 5 and 7 at one, five and ten minutes, respectively.

(13). Twin B was transported from the OR to the neonatal intensive care unit (NICU). He was noted to have significant bruising on his head, right eye and right earlobe. He was subsequently noted to have a subdural hematoma and diffuse subgaleal hemorrhages with anemia.

32B. On November 3, 2012, Dr. Alas entered a late entry note into the EMR at 7:33 p.m., summarizing her observations in the OR:

> When arrived in OR at approximately 0447, fetal bradycardia was noted for approximately 8-9 minutes. [Respondent] had applied vacuum with 3 pop offs per nursing at that time, however per [Respondent] there was not adequate seal with vacuum applications and the pop offs were not real. [Respondent] had just finished last vacuum application and had placed forceps upon my arrival. He notated that there was no adequate descent with vacuum but this was secondary to a poor seal. It was recommended by me that he proceed with an emergency cesarean at that time, given the fetal bradycardia was 10 minutes at that time and there was limited descent with the operative delivery as well what appeared to be a remaining high fetal head station, likely mid position. Dr. Lau, MFM on call, was notified at this time, 0449, to come to the OR for assistance in expediting a cesarean section. Nursing staff and charge RN were all concerned and recommended that we proceed with an emergent cesarean as well.
>
> After one application and pull of the forceps the fetal head was still noted to not be descending well. It was again recommended by myself that a crash cesarean be performed. [Respondent] agreed and Dr. Herrero went to rescrub to prepare. [Respondent] then applied the vacuum an additional time. It again was recommend[ed] that he stop and prepare the patient for a cesarean. After one more unsuccessful vacuum application, [Respondent] repositioned the patient for an emergent [cesarean]. Dr. Lau arrived during the last vacuum application as [Respondent] had agreed to proceed with an emergency cesarean, approximately 0452.

(Exhibit 6, pp. 59-60.)

32C. At the administrative hearing, Respondent maintained that nobody asked him to perform the C-section until he "ran into Dr. Alas outside the OR," when Respondent had already ordered the C-section. Respondent recalled that, after the fourth vacuum pull, he

walked out of the OR to scrub for surgery and Dr. Herrero was already at the scrub sink. At that point, Respondent saw Dr. Alas at the OR doorway, and she told him he needed to perform a C-section. Respondent insisted that Dr. Alas was never in the OR. This assertion runs counter to nursing notes which indicated that Dr. Alas was in the OR. However, the nursing notes did not indicate where in the OR Dr. Alas was standing, leaving open the possibility that she was at the doorway as Respondent recalled. Additionally, even if Dr. Alas had been in the OR prior to meeting Respondent at the doorway, it is possible that Respondent was unaware of her presence during a very hectic time when his attention was focused on the quick delivery of Twin B. Regardless of whether Dr. Alas was in the OR, the evidence did not establish that Respondent was told to proceed with a C-section and ignored such a request.

32D. Dr. Desai was present when the twins were born because he attends high risk deliveries where premature babies are delivered. He recalled the vacuum being applied more than once and forceps being used. However, he did not recall anyone in the OR telling Respondent not to use the vacuum or forceps. Dr. Desai opined that the cause of Twin B's subdural hemorrhage and subgaleal hemorrhage was likely related to the application of the vacuum and the forceps. Dr. Desai confirmed that subgaleal hemorrhage is a known complication of vacuum delivery.

33A. At the administrative hearing, Respondent explained his thought process for the delivery of Twin B. He noted that his goal is always to ensure a healthy baby and healthy mother. When a baby is bradycardic, he strives to get the baby delivered quickly. When Twin B did not emerge despite CO's pushing, Respondent decided to use a vacuum to assist. Respondent admitted it was "not ideal" to attempt vacuum delivery on a baby at zero station due to the risk of ineffectiveness. However, he was not expecting any impediments. Because Twin A had emerged without difficulty, Respondent thought he would be able to easily guide Twin B out in 30 to 45 seconds. Time was of the essence in getting the baby out, and he knew that it would take about three to five minutes to set up for a C-section and bring the epidural anesthesia to an incisional level.

33B. Respondent used a Kiwi vacuum with which he was very familiar, having used it hundreds of times. Prior to using the Kiwi vacuum on November 2, 2012, Respondent had read and understood the manufacturer's recommendations in its package insert.

33C. The manufacturer's package insert for the Kiwi vacuum indicated that it was designed to provide assistance in child birth for "term pregnancy." (Exhibit 20.) The instructions noted, "Vacuum assisted delivery should be abandoned and birth completed by cesarean section 1) if no descent (progress) of the head occurs after 2 tractions, 2) if delivery is not achieved or imminent after 4 tractions, or 3) if the vacuum cup detaches ('pops-off') twice." (*Ibid.*) The "conditions for close observation" included "Gestational age less than 37

weeks or [EFW] less than 2500 grams." (*Ibid.*) One of the listed warnings was: "Never . . . exceed recommended vacuums, time limits, or cup 'pop-off' applications." (*Ibid.*)

33D. Respondent recalled that when he applied the vacuum, it detached immediately on each attempt because he was unable get "traction." Respondent insisted that the term "pop off" did not apply to his attempts because, in order to pop off, there needed to be a good seal in the first place. Respondent believed that, if he had gotten traction, he could have delivered Twin B vaginally.

33E. Respondent was aware of the manufacturer's instructions, but he maintained that the precautions were "not an absolute." He acknowledged that it is "not ideal" to use the vacuum on a fetus with an EFW of less than 2500 grams, but believed that there are "certain situations where it might be a reasonable thing to do." Respondent also stated that he "tend[ed] to follow ACOG guidelines, not package inserts."

33F. A Practice Bulletin published by the American College of Obstetricians and Gynecologists (ACOG)[14] in June 2000, discussed issues regarding the use of vacuum extractors and forceps in operative vaginal delivery.

(1). The ACOG Practice Bulletin described operative vaginal deliveries as follows: "Operative vaginal deliveries are accomplished by applying direct traction on the fetal skull with forceps, or by applying traction to the fetal scalp by means of a vacuum extractor." (Exhibit 24, p.1.)

(2). The ACOG Practice Bulletin noted "These guidelines should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient. . . ." (Exhibit 24, p. 1.)

(3). The ACOG Practice Bulletin made the following recommendations: "Most authorities consider vacuum extraction inappropriate in pregnancies before 34 weeks of gestation because of the risk of fetal intraventricular hemorrhage. [¶] . . . [¶] Persistent efforts to obtain a vaginal delivery using different instruments may increase the potential for maternal and fetal injury. . . . Although studies are limited, the weight of available evidence appears to be against attempting multiple efforts at operative vaginal delivery with different instruments, unless there is a compelling and justifiable reason." (Exhibit 24, p. 5.)

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[14] ACOG is a professional membership organization of Ob-Gyns.

(4). In a concluding Summary, the ACOG Practice Bulletin noted:

> The following recommendations are based on good and consistent scientific evidence (Level A):
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> Both forceps and vacuum extractors are acceptable and safe instruments for operative vaginal delivery. Operator experience should determine which instrument should be used in a particular situation. [¶]
>
> The following recommendations are based on limited or inconsistent scientific evidence (Level B): [¶] . . . [¶]
>
> The incidence of intracranial hemorrhage is highest among infants delivered by cesarean following a failed vacuum or forceps delivery. The combination of vacuum and forceps has a similar incidence of intracranial hemorrhage. Therefore, an operative vaginal delivery should not be attempted when the probability of success is very low.

(Exhibit 24, p. 6.)

33G. Although Respondent typically follows the ACOG guidelines, he also maintained the ACOG recommendations are not the standard of care, but are "just guidelines." He recognized that variations in practice occur, and that physicians had the ability to use their judgement to deviate from ACOG recommendations. With the fetal distress arising during the delivery of Twin B, Respondent was much more concerned about possible anoxia (lack of blood flow and consequent brain injury due to oxygen deprivation), and he did not believe use of the vacuum and forceps was contraindicated. To the contrary, Respondent believed that using the vacuum and then forceps on a fetus at 32 weeks, 3 days gestation "was a very reasonable mode of action" under the circumstances. Respondent also believed he acted appropriately when he attempted a final vacuum extraction while the staff was preparing for the C-section. Since his prior attempts failed due to lack of traction, Respondent thought he might be able to achieve a good seal following the use of the forceps. Respondent believed "one last effort [to achieve vaginal delivery] was still better than going through a C-section."

34A. Following the delivery of CO's twins, Respondent dictated a "Delivery Note"/ "Cesarean Section Procedure Note." (Exhibit 6, pp. 49-50.) The pre-operative diagnosis was listed as: "breech and multiple gestation at 32 m[onths] and 2/7 w[eeks] with SROM." (Exhibit 6, p. 49.) Respondent noted a spontaneous vaginal delivery with Twin A, and "fetal distress with baby B," resulting in a C-section. (Exhibit 6, p. 49.) After describing the birth of Twin A, Respondent noted: "[A]ttention was turned to baby B, whose heart rate was depressed in the 90's. A ROM was performed, however baby did not descend. Baby B continued to have decreased heart rate so a vacuum as well as forceps were attempted to bring

the baby down but not effective. Head to[o] small for vacuum and a good application could not be obtained. Likewise, forceps also could not be applied well as the baby's head was too small. Decision was made to perform an emergency [C-]section for delivery of baby B." (Exhibit 6, p. 50.) Respondent described the C-section procedure in detail.

34B. Respondent acknowledged that the documented diagnosis of "breech" was an error, since both twins were in the vertex position. He explained that the EMR offers templates for use, and the template from the prior time he performed a C-section must have "repopulated" and he did not notice the error.

34C. Respondent also acknowledged that his notation about the use of vacuum and forceps did not include specific detail regarding his attempts. However, he did not believe he was required to provide more detail, noting that he relies on nurses' notes for details.

The Experts – Standard of Care

35A. Complainant offered the testimony of Steven Freedman, M.D., to establish the standard of care in this case. Dr. Freedman received his medical degree from Eastern Virginia Medical School in 1978. He completed an Ob-Gyn residency in 1982 at Western Pennsylvania Hospital, and he is board certified in Ob-Gyn.[15] Dr. Freedman is licensed to practice medicine in California and has been a medical expert reviewer for the Board since 2010.

35B. Complainant also offered the testimony of Phyllis Dawn Oster, M.D. to establish the standard of care in this case. Dr. Oster received her medical degree from the University of California Irvine (UCI) in 1981. She completed an Ob-Gyn residency in 1985 at UCI. She is board certified in Ob-Gyn.[16] Dr. Oster is licensed to practice medicine in California, and is employed at Memorial Care Outpatient Surgical Center with hospital privileges at Long Beach Memorial Medical Center / Miller Children's and Women's Hospital.

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[15] Dr. Freedman's curriculum vitae indicates that he has board certification through the "American College of Obstetrics and Gynecology." (Exhibit 10.) This appears to be an error. ACOG is a membership organization. Dr. Freedman's board certification would have been obtained through the American Board of Obstetrics and Gynecology, one of the specialty boards recognized by the American Board of Medical Specialties.

[16] Dr. Oster's curriculum vitae indicates that she is "Board Certified by the American College of Obstetrics and Gynecology." (Exhibit 8.) This appears to be an error. Dr. Oster's board certification would have been obtained through the American Board of Obstetrics and Gynecology. (See fn. 15.)

35C. Respondent offered the testimony of Howard Mandel, M.D., to establish the standard of care in this case. Dr. Mandel received his medical degree from New York University in 1981. He completed an Ob-Gyn residency at Cedars Sinai Medical Center in 1984 and is board certified in Ob-Gyn. Dr. Mandel is licensed to practice medicine in California. He has operated a private practice in Ob-Gyn since 1985.

35D. Respondent also offered the testimony of Michael Patrick Nageotte, M.D., to establish the standard of care in this case. In 1976, Dr. Nageotte received his medical degree from Loyola Stritch School of Medicine, in Maywood, Illinois. He completed a residency in Ob-Gyn at Harbor General Hospital, UCLA Medical Center in 1980, and a fellowship in Maternal Fetal Medicine at Long Beach Memorial Medical Center in 1982. He is board certified in Ob-Gyn and in Maternal Fetal Medicine. Dr. Nageotte is licensed to practice medicine in California. He is a Professor of Ob-Gyn at UCI, and he is the Executive Director of Graduate Medical Education and the Associate Chief Medical Officer at Long Beach Memorial Medical Center/Miller Children's and Women's Hospital. He has taught both medical students and residents.

35E. Dr. Oster knows Dr. Nageotte very well, and she respects his opinion "very much." She acknowledged that Dr. Nageotte is a perinatologist, which is a certification beyond Ob-Gyn, requiring additional years of training to address high risk pregnancies.

35F. Respondent also offered the testimony of Connie Chein, M.D. to establish the standard of care in this case. Dr. Chein received her medical degree from UCLA School of Medicine in 1975. She completed an Ob-Gyn residency at Los Angeles County USC Medical Center in 1979, and she is board certified in Ob-Gyn. Dr. Chein is licensed to practice medicine in California, and she has operated a private practice in Ob-Gyn since 1980. She worked at Cedars for almost 30 years, and since 2010, she has performed deliveries at St. Johns Health Center in Santa Monica.

35G. Drs. Freedman, Oster, Mandel, Nageotte and Chein were equally qualified to testify as experts on the standard of care in this case. Any additional weight given to one expert's testimony over the other's was based on the content of their testimonies and bases for their opinions, as set forth more fully below.

35H. Dr. Chein's testimony often took on the tenor of an advocate rather than an impartial expert. Several times on cross examination, she persistently provided lengthy argumentative responses well after she had answered the question at hand and sometimes after the next question was asked. Dr. Chein's tenacious defense of Respondent's position diminished her credibility as an expert. Furthermore, Dr. Chein acknowledged that she has known Respondent since he was an intern and resident at Cedars and she was an attending physician and Chief of Ob-Gyn there. Dr. Chein also wrote a letter of support for Respondent in this proceeding. In that letter, dated November 20, 2017, Dr. Chein stated that she was

"impressed with his sharp, mature, and hardworking attitude." (Exhibit 28.) Regarding the facts of this matter, she noted, incorrectly, that Respondent "tried once with vacuum which failed, then go straight to crash." (Exhibit 28.) In her letter and during her testimony, Dr. Chein blamed the Cedars NICU team for their subsequent management of Twin B's case, and she testified that she no longer performs deliveries at Cedars because of her "disputes with NICU." Dr. Chein's prior relationship with Respondent, her letter of endorsement, and her animosity toward the Cedars NICU all pointed to her potential bias in rendering her opinions, further diminishing her credibility as an expert. Given the foregoing, Dr. Chein's opinions are disregarded and will not be addressed below. However, discounting Dr. Chein's opinions will not impact the ultimate decision in this matter, since Respondent's two other experts' opinions were similar to Dr. Chein's, albeit presented more credibly

36. The experts addressed four areas of contention: prenatal care and treatment; use of vacuum and forceps; management of fetal distress; and medical recordkeeping.

Standard of Care - Prenatal Care (Gross Negligence; Repeated Negligence)

37A. Dr. Oster testified that the standard of care for prenatal visits includes taking the patient's weight and blood pressure, evaluating any health problems, and ordering appropriate laboratory studies. She leveled four criticisms regarding Respondent's prenatal care of Patient CO: failure to obtain and record maternal weight; failure to document the patient's blood pressure until 32 weeks gestation; failure to document a discussion of SC disease; failure to obtain a hematology consult; and failure to order a three-hour glucose tolerance test. Dr. Oster testified that Respondent's prenatal care of CO demonstrated an extreme departure from the standard of care.

37B. Dr. Oster credibly explained that noting a patient's blood pressure is extremely important because one of the complications of pregnancy is gestational hypertension. Both gestational hypertension and prior chronic hypertension can lead to a serious condition, preeclampsia, and the more critical condition, eclampsia. Dr. Oster noted that Respondent did not document the patient's blood pressure until she was at 32 weeks gestation. Because it was not documented, it is assumed that Respondent did not determine the patient's blood pressure.

37C. Although Respondent measured the twins' growth with ultrasound rather than maternal weight, Dr. Oster noted that maternal weight gain is significant for maternal health as well as fetal health and it should be measured at each visit. A large weight gain may indicate impending preeclampsia. Dr. Oster pointed out that a physician cannot look at a patient and "guestimate" her weight. Patient weight is a vital sign which must be ascertained and documented. For both blood pressure and weight, if it is not documented, the physician cannot be expected to recall these details from prior visits.

37D. Dr. Oster also noted that patient CO had a medical history of sickle cell disease, producing a risk of sickle cell crises during pregnancy. In her expert report, Dr. Oster criticized Respondent's failure to document that he and CO had discussed her sickle cell disease. (Exhibit 9, p.6.) However, as set forth in Factual Findings 8, 9, and 12, Respondent discussed CO's sickle cell disease with her at the initial visit and after receiving her first blood test results, and he briefly documented his discussions. Dr. Oster's testimony failed to address whether Respondent's documentation met the standard of care. Given the disproven factual basis and Dr. Oster's failure to address how Respondent's documentation affected her opinion, Dr. Oster's opinion regarding this issue is given no weight.[17] Moreover, the credible opinions of Dr. Mandel regarding Respondent's documentation of the patient's sickle cell disease, set forth in Factual Findings 38C, are adopted as facts herein.

37E. Although Dr. Oster's expert report contained her criticism that Patient CO "should have had a hematologist visit or consult" (Exhibit 9, p.7), Dr. Oster did not address this criticism in her testimony. Given Dr. Oster's failure to expound on this opinion, and given Respondent's experts' more persuasive testimony on this issue, the opinions of Drs. Negeotte and Mandel regarding the lack of hematology consult, set forth in Factual Findings 38D, are adopted as facts herein.

37F. Dr. Oster noted that the result from Patient CO's one-hour glucose screening test was 135 mg/dL and that "anything over 130 is considered abnormal" based on the laboratory report. According to Dr. Oster, the standard of care required that Respondent order a follow-up three-hour glucose tolerance test for CO. As detailed more fully below, the opinions of Drs. Negeotte and Mandel regarding glucose testing, set forth in Factual Findings 38E, are adopted as facts herein.

38A. Dr. Negeotte and Dr. Mandel opined that Respondent's prenatal care did not constitute gross negligence. Dr. Mandel testified that Respondent managed CO's prenatal care appropriately, was attentive to the patient, and "did a lot more that other Ob-Gyns," including an ultrasound at every visit.

38B. Dr. Negeotte pointed out that Respondent used ultrasound to assess fetal growth and that he obtained urine samples to detect any protein in CO's urine to assess for preeclampsia. Dr. Negeotte opined that Respondent was not negligent in failing to obtain and document the patient's weight because blood pressure and ultrasound readings are "surrogates" for weight in assessing maternal health and fetal growth. According to Dr. Negeotte, "this is not what we teach [medical students and residents], but it is a reasonable variation from the standard of care." While Respondent's use of ultrasound and blood pressure in lieu of maternal weight may have been an acceptable variation from, and not

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[17] "The expert's opinion is no better than the facts on which it is based." (*Kennemur v. State of California* (1982) 133 Cal.App.3d 907, 923-924.)

below, the standard of care, one of the "surrogate" measurements noted by Dr. Negeotte -- blood pressure readings -- was not documented until 32 weeks gestation. Dr. Negeotte acknowledged that he teaches medical students and residents to record maternal blood pressure during prenatal visits, and he agreed that "generally," it is not reasonable for a physician to take a patient's blood pressure and fail to record it. However, he allowed for Respondent's failure to record CO's blood pressure, stating that if the patient's blood pressure was normal, it is "okay not to record," and he credibly opined that the standard of care required documentation of "anything abnormal." In this case, Respondent testified, without contradiction, that he would have recorded any abnormal findings, and that CO did not have any abnormal blood pressure readings. Since he did not have a custom of recording only abnormal findings and since he is unable to recall what CO's undocumented blood pressure readings were, this leaves open the possibility of inadvertently undocumented abnormal findings. Nevertheless, this does not definitively establish by clear and convincing evidence that Respondent failed to document abnormal blood pressure readings. Given the foregoing, both Dr. Oster's opinions (regarding the importance of documenting blood pressure), set forth in Factual Finding 37B, and Dr. Negeotte's opinions (that Respondent's failure to document all blood pressure readings did not fall below the standard of care), are adopted as facts herein.

38C. Dr. Mandel noted that Respondent's documentation of "HbS" indicated Respondent's recognition of the patient's sickle cell disease. Dr. Mandel credibly testified that the standard of care did not require Respondent to document CO's sickle cell diseases any further. Dr. Mandel also credibly testified that the standard of care did not require Respondent's documentation of his discussion with the patient about her stable sickle cell disease and that Respondent's discussion with CO after her initial lab results "more than meets the standard of care." Dr. Mandel noted that Respondent's documentation on the lab report was sufficient documentation that CO's anemia had been explained and that there was justification for not working up the anemia.

38D. Dr. Negeotte disagreed that a hematology consult was required after CO's initial blood test indicated anemia. Seventy-five percent of pregnant patients suffer from anemia, mostly due to iron deficiency, and the patient's treatment remains under the province of the physician managing the pregnancy. Dr. Negeotte opined that the failure to obtain a hematology consult was not below the standard of care. Dr. Mandel testified in agreement with Dr. Negeotte. He noted that most patients' anemia worsens during the second trimester, but CO's was improving and apparently responding to the iron supplements Respondent had recommended. Dr. Mandel stated that he "[did] not know of any [Ob-Gyn]in the [United States] who would order a hematology consult for a patient with stable sickle cell disease and "for the most part no anemia."

38E. Drs. Negeotte and Mandel opined that Respondent's failure to order a three-hour glucose test was not below the standard of care and did not constitute gross negligence.

Dr. Negeotte acknowledged that, based on the laboratory's reference range, a three-hour glucose tolerance test would have been ordered. However, Dr. Negeotte credibly opined that laboratory parameters do not set the standard of care and that normal glucose screen results can reach 140 mg/mL based on the national reference range indicated by ACOG. Dr. Mandel agreed that the results of CO's one-hour glucose screening test (135 mg/mL) were normal. ACOG sets guidelines based on consensus opinions and scientific literature, and ACOG defers to the individual physician to decide their own cutoff, up to 140. Dr. Negeotte opined that, with lab results of 135 mg/mL, Patient CO did not need a three-hour glucose tolerance testing.

39. Regarding Respondent's prenatal care of Patient CO, Complainant established only one of the four criticisms: that Respondent failed to document CO's blood pressure until 32 weeks gestation. As set forth in Factual Finding 38B, Dr. Negeotte credibly opined that this omission did not fall below the standard of care. Additionally, in rendering her opinion that Respondent's overall prenatal care of CO was an extreme departure from the standard of care, Dr. Oster addressed the four identified criticisms as a whole. She did not address each identified failure as an isolated omission, and therefore, it is unclear whether she viewed each of the four individual omissions as a separate extreme departure from the standard of care. Furthermore, in light of Dr. Negeotte's opinion, and in the absence of Dr. Oster's opinion to the contrary, it was not established that the failure to document blood pressure was, in itself, a simple departure from the standard of care.

40. Nevertheless, Respondent's lack of blood pressure documentations constituted a failure to maintain adequate records within the meaning of Business and Professions Code section 2266. (See Factual Finding 45.) Medical documentation ensures accurate historical data since physicians cannot be expected to recall the vital signs and other information obtained from numerous patients over the course of time.

Standard of Care - Management of Fetal Distress (Repeated Negligence)

41A. Dr. Oster opined that Respondent's evaluation and treatment of fetal distress constituted a simple departure from the standard of care. According to Dr. Oster's expert report, the standard of care requires that if a fetal heart rate deteriorates, the physician should determine if the fetal monitor is providing an accurate reading (i.e., not the maternal heart rate). If distress is confirmed, a physician should attempt measures to "try to improve fetal oxygenation and uteroplacental blood flow by giving the mother oxygen [and] chang[ing] her position." (Exhibit 9, p. 5.) Dr. Oster asserted that in this case, "it does not appear that anyone monitored the [fetal] heart rate with the ultrasound machine to confirm a prolonged deceleration." (*Ibid.*) This assertion was contradicted by the evidence, as set forth in Factual Findings 29A and 30B. Given the disproven factual basis, Dr. Oster's opinion regarding this issue is given no weight. (See fn. 17.) Drs. Oster and Freedman also maintained that Respondent could have placed an internal scalp electrode on Twin B to verify fetal distress.

However, given that Respondent was monitoring the fetal heart rate by audio and visual ultrasound monitoring, Drs. Oster and Freedman did not establish by clear and convincing evidence that the scalp electrode was necessary.

41B. Dr. Negeotte credibly opined that although Respondent could have been done a better job of documenting his efforts to address the bradycardia, he did not breach the standard of care.

42. Complainant did not establish by clear and convincing evidence that Respondent was negligent in the evaluation of Twin B's fetal distress. However, Respondent's failure to document all measurements taken to prompt Twin B's heart rate to return to normal constitutes a failure to maintain adequate records within the meaning of Business and Professions Code section 2266. (See Factual Finding 45.)

Standard of Care - Use of Vacuum and Forceps (Gross Negligence; Repeated Negligence)

43. All the experts agree that, following confirmation of Twin B's fetal distress and unsuccessful attempts to return the fetal heart rate to normal, delivery should have been expedited. Respondent chose to attempt operative vaginal delivery of Twin B believing that after the birth of Twin A, this route would be more expeditious than a C-section. In hindsight, it is apparent that if Respondent had ordered the C-section at 4:44 a.m., Twin B would have likely been delivered by about 4:48 a.m. (which included allowing two to four minutes to bring the anesthesia to incisional level). The experts disagreed on whether the standard of care for expedited delivery required Respondent to proceed directly to a C-section and whether Respondent's five to six minutes of attempted operative vaginal delivery (from 4:44 a.m. until 4:50 a.m., when the C-section was ordered) was below the standard of care.

44A. Dr. Oster opined that, when Respondent determined the need for an expedited delivery due to Twin B's continued bradycardia, he should have proceeded to a C-section. Dr. Oster further opined that the use of vacuum extraction and forceps in delivery of Twin B was an extreme departure from the standard of care because this was a pre-term delivery (at 32 weeks and 2 days) and there were manufacturer and ACOG recommendations against vacuum extraction attempts at that stage of gestation and against alternating the use of vacuum and forceps.

(1). Dr. Oster's assertion of the standard of care is based in part on the vacuum manufacturer's package insert noting that vacuum use is not recommended for gestational age less than 37 weeks or an EFW less than 2500 grams. Dr. Oster stated that vacuum extraction is not recommended in pre-term infants because they have such fragile blood vessels and an increased risk of hematoma and bleeding; therefore, the physician should avoid creating undue force on the fetal head. Additionally, since the vacuum comes in only one size, it may be difficult to obtain a correct application on the pre-term infant's head.

(2). Dr. Oster pointed out that when the vacuum is applied, it creates some swelling on the fetal scalp to get traction. She described a "pop-off" as an application of the vacuum either incorrectly or with interference by other (likely maternal) tissue where the vacuum does not achieve good traction and pops off. According to Dr. Oster, with each pop-off comes a greater risk of injury. Dr. Oster asserted that the standard of care requires the physician to terminate use of the vacuum after two pop-offs. This asserted standard of care is based on the manufacturer's package insert. Dr. Oster acknowledged that the package insert does not set the standard of care, but she maintained that "it is consistent with the standard of care." Dr. Oster opined that after two pop-offs, the physician should recognize that the vacuum is "not going to work" and refrain from further use.

(3). Dr. Oster further opined that it was not appropriate for Respondent to return to attempted vacuum extraction after use of forceps since there had already been three pop-offs. Dr. Oster stated that the standard of care is "what most physicians in the community would do" but that is often based on recommendations by ACOG. Dr. Oster acknowledged that ACOG has not issued a statement that absolutely recommends against using a vacuum on a baby at 32 weeks gestation, and she agreed that the physician has the discretion to use a vacuum. However, she noted that AGOG does not state that a physician may continue to use a vacuum through several pop-offs until the baby is delivered. Dr. Oster opined that the physician must be willing to terminate use of the vacuum and proceed with a C-section if there are pop-offs without obtaining descent.

(4). Dr. Oster also opined that the standard of care requires that the vertex be at the perineum and visible before applying the vacuum. In this case, the vacuum was applied at zero station, which too high of a station to apply the vacuum.

(5). Dr. Oster acknowledged that Respondent was trying to deliver Twin B as soon as possible and that it did not take a lot of time to attempt vacuum extraction. She also acknowledged that subgaleal hematoma is a known complication of vacuum assisted delivery, and the presence of subgaleal hematoma does not necessarily indicate that the physician was negligent.

44B. Dr. Freedman opined that it was not appropriate to use the vacuum on Twin B. He opined that the standard of care prohibits the use of vacuum extraction in babies under 34 weeks of gestation. He noted that ACOG guidelines and the manufacturer package insert recommend against vacuum extraction on babies under 34 weeks of gestation because of the risk of fetal intraventricular hemorrhage.

(1). Dr. Freedman pointed to the reduced likelihood of success and potential for injury. He noted that Twin B never descended past zero station which would greatly reduce the odds of a successful delivery. Additionally, in this case, the fetus was in occiput posterior position (i.e., baby facing upward rather than facing down) making a good

application of the vacuum very challenging. Furthermore, in attempting proper application, the physician would have to place the vacuum cup very far posterior on the head which could create a shearing motion on the cup when the physician tries to pull, potentially causing damage to the baby. According to Dr. Freedman, each inadequate application and pop-off is potentially traumatic to the baby.

(2). Dr. Freedman also pointed out the delay in using the vacuum. He explained that a vacuum is used to guide the vertex of the fetus through the pelvis and out of the birth canal as opposed to delivery by extraction through manual removal with forceps. Vacuum delivery is dependent on the mother pushing through contractions, and therefore use of the vacuum requires the physician to wait for contractions and is time-consuming. Although Dr. Freeman noted that forceps delivery would have been the better initial alternative to facilitate extraction of the fetus independent of the mother's expulsive efforts, he also noted ACOG's indication that serial applications of vacuum and forceps are discouraged due to increased risk of injury.

(3). Dr. Freedman explained that, after the first twin is delivered, this may cause a rapid decompression of the uterus, which in turn may cause stress on the second twin or result in abruption of the second twin's placenta. Ob-Gyns use a "double set-up" where the mother is taken to the OR for delivery either vaginally or by C-section, with the idea that if a problem arises following vaginal delivery of the first twin, a C-section can be performed expeditiously. Dr. Freedman opined that Respondent should have known that he should not have used a vacuum on a 32-week gestation fetus, occiput posterior at zero station, and the C-section could have been performed quickly. However, Dr. Freedman acknowledged that ACOG does not have "hard and fast rules," allowing for physicians to use their own judgment.

44C. Dr. Negeotte opined that Respondent did not deviate from the standard of care in the delivery of Twin B. He pointed out that a subsequent adverse event does not indicate that the physician acted below the standard of care. Dr. Negeotte acknowledged that an emergency arose after Twin B's heart rate decelerated and that time was of the essence to complete delivery. However, he noted that after the delivery of Twin A, the mother's vagina was looser, and it would be expectedly easier to deliver Twin B vaginally. It is the Ob-Gyn's role to make decisions quickly, and Dr. Negeotte opined that Respondent's judgment was reasonable, and his decisions to use the vacuum and then the forceps in the setting of ongoing fetal distress were within the standard of care. He agreed that after use of the forceps with no descent, Respondent should have (and did) convert to a C-section.

(1): Dr. Negeotte disagreed that the standard of care prohibited the use of vacuum extraction for a fetus less than 34 weeks gestation. He noted that manufacturer guidelines do not establish the standard of care. He also noted that there is little data to

suggest increased danger to the fetus. Subgaleal hematomas are a known complication with vacuum use at any gestational age.

(2). Dr. Negeotte pointed out that ACOG specifically states that its guidelines do not dictate the exclusive course of treatment and that variations in practice may be warranted based on the needs of the individual patient. While Dr. Negeotte supports the position that care must be taken and that use of the vacuum should be avoided in fetuses less than 34 weeks gestation, this remains a discretionary option, and physicians must use their clinical judgment on a case-by-case basis. If there is no fetal emergency, a physician would typically avoid use of instrumentation in a fetus less than 2500 grams, but the physician must look at the risks posed in the clinical situation. Dr. Negeotte noted a statement in the ACOG Practice Bulletin stating: "Both forceps and vacuum extractors are acceptable and safe instruments for operative vaginal delivery. Operator experience should determine which instrument should be used in a particular situation." (Exhibit 24, p. 6.) Dr. Negeotte believes this supports his position.

(3). Dr. Negeotte also disagreed with Dr. Oster's assertion that the standard of care for vacuum use requires the vertex to be at the perineum and visible, noting that most vacuums are applied when the fetus is at plus 1 or plus 2 station.

(4). Dr. Negeotte acknowledged that the manufacturer guidelines suggest that vacuum use should be terminated after two pop-offs, but as noted above, he does not believe that manufacturer guidelines establish the standard of care. He also noted that this recommended limitation on the number of pop-offs is due to low likelihood of success as opposed to increased injury or morbidity. Dr. Negeotte pointed out that the ability to get a good seal is common with second twin birth; when the vacuum is applied to the fetal head, the physician has to ensure that the vacuum is not catching part of the cervix or it will pop off.

(5). Dr. Negeotte maintained that a limitation on the number of pop-offs applies only if there is no gain in station. In this case, there was no gain in station. (See Factual Findings 32A(7) and (9).) Dr. Negeotte noted that, while preparing a patient for C-section, the physician could continue to attempt vaginal birth without delaying the progression to C-section. However, Dr. Negeotte opined that, if Respondent made a fourth attempt at vacuum extraction when the patient was being prepared for C-section and if there had been "absolutely no [prior] descent" or gain in station, the fourth attempt would be below the standard of care, but not a gross departure.

44D. Dr. Mandel's testimony generally concurred with Dr. Negeotte's. Dr. Mandel agreed that due to Twin B's fetal distress, time was of the essence, and he noted that a second twin is typically easier to deliver vaginally than the first twin. Dr. Mandel characterized this case as "an exception to the rule." He disagreed that Respondent wasted time prior to

ordering the C-section. After taking time to define fetal distress, Respondent used an additional six minutes to attempt vacuum and forceps delivery.

44E. While all of the experts' testimony was equally credible, the testimony of Drs. Negeotte and Mandel was slightly more persuasive in considering the standard of care with respect to the specific circumstances Respondent faced in this case. While physicians generally refrain from using a vacuum with pre-term infants based on caveats in the manufacturer's package insert and ACOG Practice Bulletin, the standard of care does not absolutely prohibit the use of a vacuum in pre-term cases. The standard of care must be viewed as an overlay in similar circumstances, in this case the emergent delivery of a pre-term twin following normal vaginal delivery of its sibling. The evidence established that it was reasonable for Respondent to attempt vacuum-assisted vaginal birth in such a situation. The credible testimony of Drs. Negeotte and Mandel established that Respondent was not limited by the manufacturer's package insert to two pop-offs and that in this situation, three attempts at vacuum-assisted delivery followed by use of forceps before conversion to C-section did not constitute gross negligence. Dr. Negeotte noted that Respondent engaged in a simple departure from the standard of care with his fourth attempt at vacuum extraction after no prior descent. However, this sole departure from the standard of care did not constitute gross negligence and, in itself, did not constitute a repeated act of negligence.[18]

Standard of Care - Medical Recordkeeping

45A. Complainant leveled several criticisms regarding Respondent's medical recordkeeping, pertaining specifically to his prenatal records, his failure to document efforts to address fetal distress, his initial admitting note at the hospital, and his operative report. Respondent's faulty recordkeeping has been addressed above regarding his failure to document the patient's blood pressure in her prenatal records (Factual Findings 38B, 39 and 40) and regarding his failure to adequately document efforts to address fetal distress (Factual Findings 41B and 42). Complainant's two remaining criticisms are addressed below.

45B. Dr. Oster opined that Respondent's admitting history and physical and his operative report each constituted a simple departure from the standard of care. Dr. Oster noted that the consulting physicians in the hospital provided a much more detailed report than Respondent. Dr. Oster also noted that Respondent's operative report noted inaccurately that the baby was in a breech position.

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[18] Gross negligence is demonstrated by "lack of scant care" or "extreme departure from the standard of conduct/care." (*Kearl v. Bd of Med Quality Assur.* (1986) 189 Cal.App.3d 1040, 1053; *Gore v. Board of Med. Quality Assur.* (1980) 110 Cal.App.3d 184, 197.)

45C. Dr. Freedman opined that Respondent's recordkeeping was "highly inadequate." He noted that the standard of care is to treat operative vaginal deliveries like operations and that requires "extensive notations." According to Dr. Freedman, this would include: the mother's status; the gestational age; the babies' positions and station; the mother's anesthesia; positioning of the mother when the procedure was performed; the vacuum used; the type of forceps used; where the cup of the vacuum was applied; how many pulls were attempted; and how long the vacuum was applied to the baby's scalp. Dr. Freedman pointed out that Respondent noted only that the vacuum and forceps were used, with no details

45D. Drs. Mandel and Negeotte opined that Respondent's medical recordkeeping met the standard of care.

(1). Regarding the admitting history and physical, Dr. Mandel noted that Cedars has three maternity units for different levels of care, and Patient CO was admitted first to the Maternal Fetal Care Unit, which is a level of care controlled by the resident house staff. Consequently, the admitting history and physical must be done by the house officer, and in this case it was completed by Maternal Fetal Medicine Fellow, Dr. Lau, under the supervision of Dr. Williams, a full professor at UCLA and one of the heads of Maternal Fetal Medicine at Cedars. According to Dr. Mandel, when a patient is transferred from the Maternal Fetal Care Unit to the active labor and delivery unit, there is a transfer of the physician in charge from the Maternal Fetal Medicine professor to the private attending physician. Dr. Mandel explained that, when Patient CO was in the Maternal Fetal Care Unit, Respondent was not authorized to call in orders there. However, once the patient was transferred to the labor and delivery unit, Respondent was authorized to, and did, call in labor and delivery orders. Dr. Mandel understood that Cedars viewed the Maternal Fetal Medicine consultation report – in this case, Dr. Lau's report -- as the formal history and physical for the patient's chart, as opposed to Respondent's brief note. Dr. Mandel opined that the standard of care allows that initial history and physical to carry through the patient's hospitalization with updates. He also opined that Respondent's abbreviated initial note met the standard of care. Dr. Negeotte agreed that Respondent's initial note was not below the standard of care, and that it was an accurate and adequate medical record.

(2). Regarding the operative report, Dr. Negeotte acknowledged that "any delivery could be described in multiple paragraphs of prose, but that is not what the standard of care requires." He agreed that the standard of care requires documentation of the number of vacuum pulls, but there is an understanding that the nurses will document the number and duration of vacuum attempts. Dr. Mandel concurred that the standard of care allows for nurses notes and delivery records to be incorporated to provide all pertinent information. In this case, Respondent noted his use of the vacuum and the nurses documented the number and time of attempts. Dr. Negeotte credibly opined that the information Respondent and the nurses recorded met the standard of care.

(3). Dr. Negeotte and Dr. Mandel both acknowledged that the preoperative diagnosis of "breech" was inaccurate. Typically, the operative report should be reviewed for accuracy before signing. However, Dr. Mandel noted that a lot of EMR notes are templated and typographical errors are a common problem with templated notes. This oversight did not fall below the standard of care.

45E. Regarding Respondent's medical recordkeeping in relation to his initial admitting note and his operative report, the opinions of Drs. Negeotte and Mandel were more persuasive than those of Drs. Oster and Freedman. Consequently, the opinions of Drs. Negeotte and Mandel as set forth in Factual Finding 45D, are adopted as facts herein.

45F. Respondent's testimony established that, despite Respondent being listed as the patient's "admitting" physician," Respondent did not conduct the admitting history and physical at the hospital, and Respondent's concise note, entered into the Cedars EMR as a "history and physical" was extraneous and an attempt to get the patient admitted faster. Consequently, that note in the EMR does not constitute a failure to keep adequate records. Additionally, while the majority of Respondent's operative report constituted an adequate medical record, Respondent's inaccurate preoperative diagnosis of "breech" in his operative report constituted a failure to maintain accurate records within the meaning of Business and Professions Code section 2266.

45G. Respondent's failure to document blood pressure readings until 32 weeks gestation, failure to document efforts made to address fetal distress, and inaccurate preoperative diagnosis in his operative report collectively constituted a failure to maintain adequate and accurate records as required by Business and Professions Code section 2266.

Respondent's Background, Rehabilitation & Character Evidence

46. Respondent has been in private practice as an Ob-Gyn for 19 years, and he is board certified in Ob-Gyn. He has been an assistant clinical professor with UCLA School of Medicine (although currently on hiatus). He has served on several committees at Cedars, including the Medical Executive Committee (2008-2012). He was chosen as Vice Clinical Chief of Obstetrics (2013-2015) and Clinical Chief of Obstetrics and Gynecology (2015-2017).[19]

47. Respondent has performed approximately 120 to 150 deliveries per year during his years in practice. He has not been disciplined by any hospitals regarding the care he has provided to patients.

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[19] Respondent noted that, at Cedars there is a Vice Chief of Obstetrics, a Vice Chief of Gynecology, and a Chief of Obstetrics and Gynecology that oversees those two positions.

48. On December 6, 2017, Respondent enrolled and paid fees to participate in the Medical Records Course offered by Professional Boundaries, Inc. through the University of California Irvine, scheduled for April 14, 2018.

49. Anesthesiologist Dr. Kim has worked with Respondent at Cedars since 2011, providing anesthesia for deliveries once or twice per week. Dr. Kim characterized Respondent as an outstanding physician.

LEGAL CONCLUSIONS

Causes for Discipline[20]

1. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Complainant failed to establish, by clear and convincing evidence, that Respondent committed gross negligence through use of the vacuum and forceps in the delivery of Twin B, as set forth in Factual Findings 1 through 45.

2. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (b), in that Complainant failed to establish, by clear and convincing evidence, that Respondent committed gross negligence in the prenatal care of Patient CO, as set forth in Factual Findings 1 through 45.

3. Cause does not exist to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2234, subdivision (c), in that Complainant failed to establish, by clear and convincing evidence, that Respondent committed repeated negligent acts in his care of Patient CO, as set forth in Factual Findings 1 through 45. Although Respondent engaged in a simple departure from the standard of care with his fourth attempt at vacuum extraction after no prior descent, this single instance of negligence does not constitute repeated negligent acts in the treatment of CO.

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[20] The standard of proof which must be met to establish the charging allegations is "clear and convincing evidence." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (*Katie V. v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

4. Cause exists to discipline Respondent's physician's and surgeon's certificate, pursuant to Business and Professions Code section 2266, in that Respondent failed to maintain adequate and accurate records in his care of patient CO (by his failure to document blood pressure readings until 32 weeks gestation, failure to document efforts made to address fetal distress, and inaccurate preoperative diagnosis in his operative report), as set forth in Factual Findings 1 through 45.

Analysis re: Level of Discipline

5A. Complainant established that Respondent engaged in a failure to maintain adequate and accurate records by his failure to document blood pressure readings until 32 weeks gestation, failure to document efforts made to address fetal distress, and inaccurate preoperative diagnosis in his operative report. The remaining question is the nature of the discipline to be imposed against Respondent's certificate for his violations.

5B. Business and Professions Code section 2229 provides, in pertinent part:

> (a) Protection of the public shall be the highest priority for the Division of Medical Quality, . . . and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
>
> (b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, [or] the division, . . . shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee . . . .

5C. Business and Professions Code section 2227, subdivision (a), provides:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, . . . and who is found guilty, or who has entered into a stipulation for disciplinary action with the division, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the division.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the division.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the division.

(4) Be publicly reprimanded by the division.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the division or an administrative law judge may deem proper.

5D. The established area of concern in this case involves Respondent's occasional deficiency in maintaining adequate and accurate records. In this case: Respondent took the patient's blood pressure, but failed to document blood pressure readings until 32 weeks gestation; he addressed fetal distress but failed to document the efforts made to address fetal distress; and he inadvertently but inaccurately noted a "breech" preoperative diagnosis in his operative report. Respondent has already enrolled in a medical recordkeeping course to remedy his recordkeeping deficiency. Given that protection of the public is the primary purpose of the Board, Respondent has demonstrated his desire to work in conjunction with the Board on its paramount goal of patient safety.

5E. In this case, cause for discipline exists, and the Board must acknowledge, to both the public and the medical community, that the acts and omissions of Respondent were not in compliance with Business and Profession Code section 2266. In light of Respondent's 19-year history of licensure without prior discipline and his demonstrated willingness to improve his recordkeeping skills, a public reprimand with a required recordkeeping course will best protect the public without imposing overly harsh and punitive discipline on Respondent.

ORDER

1. Respondent is hereby reprimanded within the meaning of Business and Professions Code section 2227, subdivision (a)(4).

2. Medical Record Keeping Course: Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a medical record keeping course approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education requirements for renewal of licensure.

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A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee no later than 15 calendar days after successfully completing the course, or no later than 15 calendar days after the effective date of the Decision, whichever is later.

DATED: February 26, 2018

DocuSigned by:
Julie Cabos-Owen
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JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings

XAVIER BECERRA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 897-2655
Facsimile: (213) 897-9395
Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: ANTHONY BAXTER CHIN, M.D. 415 North Crescent Drive, Suite 100 Beverly Hills, California 90210 Physician's and Surgeon's Certificate No. A61618, Respondent.	Case No. 800-2015-011874 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California ("Board").

2. On February 14, 1997, the Board issued Physician's and Surgeon's Certificate Number A61618 to Anthony Baxter Chin, M.D. ("Respondent"). That license was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2018, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following provisions of the California Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2004 of the Code states:

"The board shall have the responsibility for the following:

"(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

"(b) The administration and hearing of disciplinary actions.

"(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

"(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

"(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

"..."

5. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

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"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

6. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"..."

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7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FACTUAL ALLEGATIONS

8. Patient C.O. was a pregnant 31-year-old female, gravida 3, para 0 when she sought prenatal care with Respondent on June 8, 2012.[1] At the first prenatal visit with Respondent, ultrasound revealed a twin gestation. Patient C.O.'s last menstrual period was March 21, 2012, giving her an estimated date of confinement of December 26, 2012. On Patient C.O.'s initial intake form, it is noted under her medical and surgical history that she had a blood transfusion in 1990 and has sickle cell disease.

9. Patient C.O. had eleven prenatal visits with Respondent. An ultrasound was performed at each visit to measure the growth of the twins. Patient C.O. had initial prenatal laboratory work performed on June 12, 2012 which reflected a low red blood cell count, low hemoglobin and low hematocrit. She participated in the California Prenatal Screening Program which was negative for abnormality. She had a formal ultrasound done at Cedars-Sinai Medical Center ("the hospital") on August 6, 2012. During the second trimester, Patient C.O.'s laboratory work reflected a low red blood cell count and low hematocrit. She also had a one hour glucose tolerance test performed with results of 135 mg/dL. Respondent did not record maternal weight during his prenatal care and treatment of Patient C.O. Respondent did not record Patient C.O.'s blood pressure until her October 31, 2012 visit at 32 weeks gestation.

10. On November 2, 2012, at 32 weeks + 2 days gestation, Patient C.O. called Respondent with a complaint of spontaneous rupture of membranes. At Respondent's request, Patient C.O. presented to Respondent's office, at which time he verified the spontaneous rupture of membranes and sent her to the hospital for further treatment.

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[1] Initials are used for privacy purposes.

11. Patient C.O. presented to the hospital as instructed. Respondent prepared a brief History and Physical Report with a plan of expectant management, antibiotic therapy and steroid therapy. He did not document vital signs or the patient's obstetrical history.

12. Patient C.O. was seen in consultation at the hospital by perinatologist, Dr. J.W. and perinatal resident, Dr. G.L. Drs. J.W. and G.L. recommended a steroid (Betamethasone 12 milligrams every 24 hours in two doses) and antibiotics (erythromycin and ampicillin for 7 days with delivery at 34-35 weeks) for treatment of preterm labor. An ultrasound was performed to confirm presentation and size estimate. Both twins were in vertex position.[2] Twin B was larger than Twin A with 15% discordance in size. The recommended steroid and antibiotic treatment was initiated. Patient C.O. was also seen by neonatologist Dr. V.M. in consultation prior to delivery. Patient C.O. began to have regular contractions and at 10:12 p.m. that same day, was evaluated by anesthesiologist, Dr. P.K. for an epidural.

13. Patient C.O. was evaluated by a third year resident on the obstetrical service at 4:03 a.m. on November 3, 2012. She was having rectal pressure and upon examination, she was 10 centimeters dilated at plus 2 station.[3] The fetuses were being monitored by an external heart monitor.[4] The fetal monitor strips were reassuring. Respondent was called and Patient C.O. was moved to the operating room for delivery.

14. Respondent arrived at approximately 4:15 a.m. At 4:38 a.m., Respondent delivered Twin A by normal spontaneous vaginal delivery. Twin A was 3 pounds, 4 ounces and had APGARs of 8 and 9 at one and five minutes, respectively.[5]

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[2] Vertex position is where the fetus is in a longitudinal lie and the head enters the pelvis first (i.e., head-first presentation).

[3] Dilation, measured in centimeters, describes how widened the cervix has become. Fetal station describes how far down the fetus' head has descended into the pelvis and is the measurement of the fetus relative to the ischial spines (i.e., +2 is 2 cm below the ischial spines).

[4] External fetal heart rate monitoring uses a device to listen to or record the fetal heartbeat through the mother's abdomen. Internal fetal heart rate monitoring uses a wire electrode attached to the fetal scalp.

[5] APGAR is a quick, overall assessment of newborn wellbeing used immediately following the delivery of a baby measuring the baby's color, heart rate, reflexes, muscle tone and respiratory effort. Each category is scored with 0, 1, or 2, depending on the observed condition. The Apgar score is based on a total score of 1 to 10. The higher the score, the better the baby is doing after birth. A score of 7, 8, or 9 is normal

(continued...)

15. Following delivery of Twin A, there was an audible deceleration in the heart rate of Twin B. The position of Twin B was confirmed to be vertex by ultrasound. Respondent ruptured the membranes. There was no documentation of monitoring the heart rate with the ultrasound machine to confirm a prolonged deceleration. There was no placement of an internal fetal heart rate monitor to verify fetal distress. No measures to allow the heart rate to return to normal were documented.

16. Following the rupture of membranes, Respondent asked for the Kiwi vacuum and applied it three times with pop-offs.[6] The vertex remained at 0 station with no descent.

17. Respondent then asked for forceps.[7] He again attempted delivery but could not achieve a good application and failed to bring the head down.

18. Following the use of forceps, Respondent asked the operating room to prepare for cesarean section. While the operating room was preparing for the cesarean section, Respondent reapplied the vacuum one more time, which was again unsuccessful and he then proceeded with the primary cesarean section. Twin B was delivered at 4:54 a.m. weighing 4 pounds and 3 ounces with APGAR scores of 3, 5 and 7 at one, five and ten minutes, respectively.

19. Twin B was transported directly to the neonatal intensive care unit ("NICU") from the delivery room. He was noted to have significant bruising on his head, right eye and right earlobe. He was subsequently noted to have a subdural hematoma and diffuse subgaleal hemorrhages with anemia. He had seizures in the NICU. He remained hospitalized for one month after delivery. He continues to have developmental delays, both cognitive and physical.

20. Respondent dictated a Cesarean Section Procedure Note wherein his pre-operative diagnosis was noted to be breech and multiple gestation at 32 and 2/7 weeks with spontaneous

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(...continued)
and is a sign that the newborn is in good health. Any score lower than 7 is a sign that the baby needs medical attention.

[6] A Kiwi vacuum is a brand of vacuum device that is used to help guide the fetus out of the birth canal. A soft cup attaches to the fetal head for traction. "Pop-offs" are disengagements of the vacuum.

[7] Forceps are a surgical instrument used for applying direct traction to the fetal skull to effect a vaginal birth.

rupture of membranes. He noted that vacuum and forceps were attempted without specific detail regarding the attempts.

STANDARD OF CARE

21. The standard of medical practice in California requires that a practitioner not use a vacuum in a fetus less than 34 weeks gestation. Further, the standard of medical practice in California requires that before a practitioner applies the vacuum, the vertex should be at the perineum and visible (i.e., +1 or +2). In addition, when a practitioner uses a vacuum, the standard of medical practice in California requires that the vacuum procedure be terminated after three pop offs. While forceps may be used to expedite a delivery of a preterm infant, the use of both vacuum and forceps sequentially to achieve a vaginal delivery is not recommended.

22. With respect to management of fetal distress, the standard of medical practice in California requires that a practitioner evaluate the fetal monitor tracing to determine if the reading is accurate, determine if there is an identifiable cause for the distress and attempt to improve fetal oxygenation and uteroplacental blood flow by giving the maternal patient oxygen, changing the maternal patient's position, turning off Pitocin if it is running and if there is no improvement, expedite delivery.

23. With respect to prenatal care and treatment, the standard of medical practice in California requires that a practitioner see the patient regularly for prenatal care and at those visits, record blood pressure, weight gain, fundal height and fetal heart tones. The patient's urine also needs to be checked for the presence of sugar and protein. In addition, other medical problems need to be evaluated, prior surgeries listed and appropriate laboratory studies ordered and evaluated.

24. The standard of medical practice in California requires that a practitioner keep accurate, complete and legible medical records.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Use of Vacuum/Forceps in a Preterm Delivery)

25. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence in the indication and manner of use of the

vacuum and forceps in the delivery of Twin B. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 21, above, as though fully set forth herein. The circumstances are as follows:

A. Following delivery of Twin A, Twin B had a drop in heart rate that did not return to normal. Respondent then confirmed presentation, ruptured the membranes and attempted a vacuum assisted delivery of Twin B at 32 weeks 3 days gestation.

B. Despite his inability to achieve a good seal with the vacuum with three pop-offs, Respondent continued to attempt vaginal delivery without advancing the station.

C. Respondent then attempted a forceps delivery which was unsuccessful and did not advance the station.

D. Respondent thereafter called for a cesarean section. While the operating room staff prepared for the cesarean section, Respondent made another unsuccessful attempt at vacuum delivery.

26. Respondent's acts and/or omissions as set forth in paragraphs 8 through 21, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence – Prenatal Care)

27. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence in the prenatal care of Patient C.O. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 11 and 23, above, as though fully set forth herein. The circumstances are as follows:

A. Patient C.O. had eleven prenatal visits with Respondent and maternal weight was not measured as a part of her prenatal care and her blood pressure was not recorded until the visit on October 31, 2012 at 32 weeks.

B. On Patient C.O.'s initial prenatal intake form, it is noted under her medical and surgical history that she has sickle cell disease; however, there is no documentation in her chart that her disease was discussed.

C. Given Patient C.O.'s anemia, confirmed by laboratory studies, a hematology consult should have been obtained.

D. Given Patient C.O.'s abnormal one hour glucose tolerance test, a three hour test should have been ordered.

28. Respondent's acts and/or omissions as set forth in paragraphs 8 through 11 and 23, above, whether proven individually, jointly, or in any combination thereof, constitute gross negligence pursuant to section 2234, subdivision (b), of the Code. Therefore cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence)

29. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the obstetrical care and treatment of Patient C.O. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 23, above, as though fully set forth herein.

A. Respondent was negligent in the use of the vacuum and forceps in the delivery of Twin B. The circumstances are as follows:

i. Following delivery of Twin A, Twin B had a drop in heart rate that did not return to normal. Respondent then confirmed presentation, ruptured the membranes and attempted a vacuum assisted delivery of Twin B at 32 weeks 3 days gestation.

ii. Despite his inability to achieve a good seal with the vacuum with three pop-offs, Respondent continued to attempt vaginal delivery without advancing the station.

iii. Respondent then attempted a forceps delivery which was unsuccessful and did not advance the station.

iv. Respondent thereafter called for a cesarean section. While the operating room staff prepared for the cesarean section, Respondent made another unsuccessful attempt at vacuum delivery.

B. Respondent was negligent in the prenatal care of Patient C.O. The circumstances are as follows:

i. Patient C.O. had eleven prenatal visits with Respondent and maternal weight was not measured as a part of her prenatal care and her blood pressure was not recorded until the visit on October 31, 2012 at 32 weeks.

ii. On Patient C.O.'s initial prenatal intake form, it is noted under her medical and surgical history that she has sickle cell disease; however, there is no documentation in her chart that her disease was discussed.

iii. Given Patient C.O.'s anemia, confirmed by laboratory studies, a hematology consult should have been obtained.

iv. Given Patient C.O.'s abnormal one hour glucose tolerance test, a three hour test should have been ordered.

C. Respondent was negligent in the evaluation and treatment of Twin B's fetal distress; in that, following delivery of Twin A, there was a deceleration in the heart rate of Twin B. There was no documentation of monitoring the heart rate with the ultrasound machine to confirm a prolonged deceleration. There was no placement of an internal fetal heart monitor to verify fetal distress. No measures to allow the heart rate to return to normal were documented.

30. Respondent's acts and/or omissions as set forth in paragraphs 8 through 23, above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of negligence pursuant to section 2234, subdivision (c), of the Code. Therefore cause for discipline exists.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

31. Respondent is subject to disciplinary action under section 2266 of the Code for failing to maintain adequate and accurate records relating to his care and treatment of C.O. Complainant refers to and, by this reference, incorporates herein, paragraphs 8 through 24, above, as though fully set forth herein.

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32. Respondent's acts and/or omissions as set forth in paragraphs 8 through 24, above, whether proven individually, jointly, or in any combination thereof, constitute the failure to maintain adequate records pursuant to section 2266 of the Code. Therefore cause for discipline exists.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 61618, issued to Anthony Baxter Chin, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants and advanced practice nurses, pursuant to section 3527 of the Code;

3. If placed on probation, ordering him to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: April 18, 2017

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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